Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002870	A. BUILDING _____ B. WING _____	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITAL HOME & HEALTHCARE INC	8840 CALUMET AVE STE 102 B MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was a home health agency state licensure survey. Survey Date: January 31 and February 1 and 4, 2013. Facility #: 2870. Medicaid Vendor #: N/A. Surveyor: Janet Brandt, RN, PHNS. Total number of records reviewed: 5 Closed records: 1 Open records: 4 Home visits: 3. Total unduplicated census: 173. Vital Home & Healthcare Inc is in compliance with the Indiana Rules for home health agency licensure 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN February 6, 2013	N 000		